Wisconsin Health Insurance Risk Sharing Plan (HIRSP)

Suite 18, 6406 Bridge Road, Madison, Wisconsin 53784-0018
Telephone (608) 221-4551 (local), 1-800-828-4777 (toll free)

Application Form

☐ **PLAN 1, Option A** ($1,000 Deductible)
☐ **PLAN 1, Option B** ($2,500 Deductible)
☐ **PLAN 2 (MEDICARE ONLY)** ($500 Deductible)

Section 1. Insured Information

1. Proposed Insured	Last Name	First	Middle	1A. Sex ☐ M ☐ F	1B. Telephone Number ( ) -
1C. Residence Address	Number and Street	City	State ZIP Code		1D. Date of Birth (MM/DD/YYYY)
1E. Social Security Number	1F. Marital Status	Single ☐	Married ☐	Widowed ☐	Divorced ☐ Separated ☐

Section 2. Other Family Members Enrolled in HIRSP

Is another person in your family applying for or insured under HIRSP? ☐ YES ☐ NO

If "YES," please provide the following information:

Name	Date of Birth (MM/DD/YYYY)
Relationship	
Policy Identification Number or Social Security Number of Person Insured	

NOTE: Every person applying for HIRSP coverage, even if in the same family, must complete a separate application.

Section 3. Employer Health Insurance

3A. Are you (or your parent, if a dependent child) currently:

☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed ☐ Unemployed ☐ Retired

3B. Is your spouse currently:

☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed ☐ Unemployed ☐ Retired

If you and/or your spouse (or parents, if a dependent child) ***ARE NOT UNEMPLOYED,*** answer ***3C, 3D, 3E, 3F, and 3G.***

3C.	YOUR EMPLOYER (or parent's employer if dependent child)	3D. SPOUSE'S EMPLOYER
Name:		
Street Address:		
City, State, ZIP:		
Number of Employees:	☐ 2-25 ☐ 26-50 ☐ Over 50	☐ 2-25 ☐ 26-50 ☐ Over 50

3E. Does your employer, your spouse's employer, or in the case of a dependent child, your parent's employer, have a health insurance plan available for employees? ☐ YES ☐ NO

3F. If you answered "YES" to 3E above, are you eligible for any employer's health insurance? ☐ YES ☐ NO

3G. If you answered "NO" to 3F above, please give a brief explanation as to why you are not eligible to be insured under your, your spouse's, or your parent's employer's health insurance plan?

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Section 4. Resident Eligibility

I certify that I am eligible for coverage because I meet the following requirements.

Resident means a person who has been legally domiciled in this state for a period of at least 30 days or, with respect to an Eligible Individual (see Section 5a below), an individual who resides in this state. Legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or child's legal guardian is legally domiciled in this state. A person with a developmental disability or another disability that prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state.

I have been a resident of Wisconsin continuously since (MM/DD/YYYY)								

Section 5a. Eligible Individual

An eligible individual meets legal requirements to waive a waiting period for insurance coverage of preexisting conditions. To be an eligible individual, the applicant must meet ***ALL*** the following conditions:

- ☐ The aggregate of the individual's periods of creditable coverage is 18 months or more.
- ☐ The most recent period of creditable coverage was under a group health plan, governmental plan, or church plan.
- ☐ The individual does not currently have creditable coverage and is not currently eligible for a group health plan, Medicare, or Medicaid.
- ☐ The most recent creditable coverage was not terminated due to fraud, intentional misrepresentation, or failure to pay premium.
- ☐ If offered, the individual elected continuation coverage and exhausted the coverage.

Are you an eligible individual? ☐ **YES** ☐ **NO** **If "YES":**

- ☐ **Please attach to your application a copy of your certificate of creditable coverage for HIRSP to verify your status. If you do not have a certificate of creditable coverage, you may provide other documentation, such as pay stubs, copies of premium payments, explanations of benefits, etc.**
- ☐ **Skip Section 5b below.**

NOTE: A certificate of creditable coverage is a written certification of prior health coverage, issued by the previous health plan. The certificate must identify the covered person, period of coverage, and any waiting periods. All group health employer plans must provide certificates to individuals losing coverage after June 1, 1997.

Section 5b. Medical Eligibility (Not Required for Plan 2 Applicants)

If you are not an eligible individual as defined in Section 5a above, please indicate which of the following actions or notifications you have received in the last nine months due to health reasons:

- ☐ A notice of rejection or cancellation from one or more health insurers.
- ☐ A notice of a reduction or limitation in health insurance coverage that substantially reduces coverage when compared with coverage available to persons considered to be standard risks.
- ☐ A notice of an increase in a health insurance premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health policies then in effect.
- ☐ A notice of premium rate increase for health insurance applied for but not yet in effect. This notice must be from one or more insurers and must exceed by at least 50% the premium charged to a person considered to be a standard risk.
- ☐ Tested positive for the presence of HIV.

☐ ***I have attached to my application copies of such notice from insurance companies.***

NOTE: No person is eligible for coverage for whom a premium, deductible, or coinsurance amount is paid or reimbursed by a federal, state, county, or municipal government or agency. This does not apply if the deductible or coinsurance amount is paid or reimbursed by government programs for vocational rehabilitation, renal disease, hemophilia, cystic fibrosis, maternal and child health services, or HIV, or for persons receiving assistance for HIRSP premiums and deductibles.

Section 6. Survey Information

To help determine the value of this program for those people it covers, please state the primary health condition(s) that prevent(s) you from obtaining standard coverage. This information will not be used in determining your eligibility for coverage and will be held confidential.

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Section 7. Previous Enrollment in HIRSP

Have you ever been enrolled before in Wisconsin HIRSP? ☐ YES ☐ NO If "YES," please provide the following:

Policy Identification Number												

Cancellation Year				

NOTE: Except for an eligible individual or person who terminates coverage because he or she is eligible to receive Medicaid benefits, no person who is covered under HIRSP and voluntarily terminates HIRSP coverage is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage.

Section 8. For Persons Applying for HIRSP Plan 2 Coverage

I understand:

☐ This plan is designed for persons eligible for and enrolled in the federal Medicare program.

☐ If I am not enrolled in Part B of the federal Medicare program, the amount payable under HIRSP will not include benefits usually paid for by Medicare Plan B.

Medicare Health Insurance Number									

Section 9. Medicaid Eligibility

9A. Are you currently covered by health insurance benefits under Medicaid (also referred to as Medical Assistance or Title 19)?

☐ Yes ☐ No If "YES," please provide Medicaid number

9B. If previously covered by Medicaid, please provide cancellation date

NOTE: Provisions requiring 12 months to elapse from voluntary termination of HIRSP eligibility to return to HIRSP coverage do not apply for any person who terminates coverage under the plan because he or she is receiving, or is eligible to receive, Medicaid benefits.

Section 10. Other Medical Coverage

10A. Are you currently covered by any other medical plan? ☐ YES ☐ NO If "YES," please complete 10B and 10C.

10B. Is it a(n):

☐ Individual Medical Plan ☐ Group Medical Plan ☐ Continuation Coverage under COBRA ☐ Other

10C. Please provide the name of the insurance company or companies and policy identification number(s).

Name of Insurance Company	Policy Identification Number											

Section 11. Qualification for Premium Reduction (Not Applicable for Plan 1, Deductible Option B)

Is your annual household income less than $20,000? ☐ YES ☐ NO

If "YES," complete a Supplemental Application to see if you qualify for a premium and deductible reduction. If you did not receive a Supplemental Application, please telephone our Dedicated Insurance Service Center at 1-800-828-4777.

Section 12. Current Coverage

12A. Do you intend to terminate your present policy or policies to be replaced by HIRSP coverage?

☐ YES ☐ NO ☐ DOES NOT APPLY

12B. If YES," what would be date of termination (MM/DD/YYYY)? | | | | | | | | |

Section 13. HIRSP Effective Date

13A. The earliest effective date of your HIRSP policy can be the date a completed HIRSP application and full initial premium is received by the administrator of HIRSP. Do you request an effective date other than date received

☐ YES ☐ NO If "YES," date requested is (MM/DD/YYYY) | | | | | | | | |

NOTE: If you request an effective date other than the date received and you are not an eligible individual, your six month waiting period for coverage of preexisting conditions will begin on your requested effective date. This date cannot be more than 60 days after the signature date.

Certification and Signature

I certify that I am not currently covered under a HIRSP policy and that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until I pay the full initial premium and HIRSP approves this application. I understand that I am subject to disenrollment and possible prosecution under state and federal laws if this information is false. I authorize release to HIRSP of any medical and financial information including certification for General Assistance, Medicaid, or Medicare necessary for determining eligibility, processing claims, and verifying services under HIRSP. I will notify HIRSP (Suite 18, 6406 Bridge Road, Madison, WI 53784-0018) of any change of name, income, insurance, employment status, address, or telephone number. I understand I am responsible for all medical costs of services not covered by HIRSP. I am informed of my rights to appeal a denial or eligibility.

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Signature of Applicant Date (MM/DD/YYYY)

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Signature of Parent or Legal Guardian if Applicant is under age 18 or legally incompetent Date (MM/DD/YYYY)

Initial quarterly premium enclosed $_____ ***Make check payable to Wisconsin HIRSP.***

Have You: ☐ ***Answered all questions completely?*** ☐ ***Attached all notices as required under Section 5?***
☐ ***Included your initial premium?*** ☐ ***Signed the application?***

Failure to comply with all requirements in making application to HIRSP may delay the effective date of your policy.

Agent: Complete below if Application Has Been Made with Assistance from an Agent

Agent Name (please print)	Date	Signature
Wisconsin Insurance License Number		Tax Identification Number/Social Security Number
Address: Street, City, State, ZIP Code		